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ABSTRACT

Families are the principal influence on development in the first years of life, so the mental health of parents is an issue that affects every child in California. The most common mental health concerns facing parents involve stress and anxiety. These needs can be addressed through public health messages that de-stigmatize mental illness and through the availability of private and publicly subsidized counseling and social work services. Further along the cost and service intensity spectrum are parents who suffer from depression or panic disorder. While the number of parents with major mental illnesses is small, their service needs are substantial. In the discussion that follows, it is suggested that a balance of population-oriented prevention and support services, together with more intensive and coordinated services for higher levels of need, represents the most efficient way to meet the needs of parents with mental illness, and the children who depend upon them. Because the author's orientation is toward Proposition 10 funding for infancy and early childhood, the ways in which infants and young children can benefit from the supported involvement of their parents is emphasized. Addressing the mental health needs of parents increases the likelihood that all children in California will experience positive, nurturing, and enriching interactions with their parents. (Contains 66 references.) (GCP)

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Building Community Systems for Young Children

Building Community Systems for Young Children is a series of reports designed to support the implementation of Proposition 10: The California Children and Families Act. Each installment is written by a team of experts and provides comprehensive and authoritative information on critical issues concerning young children and families in California.

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Parental Mental Illness

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Parental Mental Illness

I. Introduction

Families are the principal influence on development in the first years of life, so the mental health of parents is an issue that affects every child in California. The most common mental health concerns facing parents involve stress and anxiety. These needs can be addressed through public health messages that de-stigmatize mental illness and through the availability of private and publicly subsidized counseling and social work services. Further along the cost and service intensity spectrum are parents who suffer from depression or panic disorder. In the United States in any one year, approximately 13% of adults of reproductive age suffer from depression, and another 2% suffer from panic disorder (Kessler et al. 1994). Clearly, moderate mental illnesses affect large numbers of families and children. Mothers and fathers of children under age 3 are particularly at risk, with rates of depression in these parents estimated at 12-19% (Lyons-Ruth et al., in press; O'Hara 1995; Areias et al. 1996). Severe mental illnesses, including manic-depressive disorder and schizophrenia, are less common, occurring in approximately 2% of the population, but produce greater impairments in parenting than do other mental illnesses. Severely mentally ill parents are at risk for homelessness and substance abuse, further jeopardizing their parenting capacities. While the number of parents with major mental illnesses is small, their service needs, and the costs of failing to address those needs, are substantial.

Efforts to address the mental health and mental illness issues of parents with young children therefore face three broad challenges:

(1) Addressing the relatively low-cost mental health concerns and needs of the entire population of parents with young children;
(2) Addressing the higher-cost, but somewhat less prevalent, issues associated with moderate mental illness;
(3) Addressing the highest-cost, but relatively rare, issues associated with major mental health problems in parents of young children.

In the discussion that follows, we suggest that a balance of population-oriented prevention and support services, together with more intensive and coordinated services for higher levels of need, represents the most efficient way to meet the needs of parents with mental illness, and the children who depend upon them. Because our orientation is toward Proposition 10 funding for infancy and early childhood, we emphasize the ways in which infants and young children can benefit from the supported involvement of their parents, even if those parents suffer from mental illness. Both public policy and long-standing tradition suggest that children should be with their parents whenever possible. Addressing the mental health needs of parents increases the likelihood that all children in California will experience positive, nurturing, and enriching interactions with their parents.

II. Review of Research and Other Evidence

Impact of parental mental illness on children

> *Parental mental illnesses can compromise parenting and increase the likelihood that a parent will use harsh methods of discipline.*

A large body of literature indicates that parental mental illnesses can compromise parenting and affect parent-child attachment patterns. The impact of parental depression on children's development has been studied more than any other mental illness, and numerous studies have found children of depressed parents are at risk for adverse outcomes in social, emotional and behavioral development during infancy, toddlerhood and later childhood. More communication difficulties, including less mutually responsive patterns of interaction, have been observed between depressed women and their 13- to-29-month-old children, compared to non-depressed mothers and their children (Jameson et al. 1997; Stein 1991). At age 2, children of depressed mothers have more difficulty with emotional regulation (Zahn-Waxler et al. 1984). Their self-esteem tends to be lower, they show more aggressive behavior toward their parents and peers at ages 3-5 years (Sinclair and Murray 1998; Alpern and Lyons-Ruth 1993; Lyons-Ruth et al. 1997), and display more negative affect towards others at ages 5-7 (Nolen-Hoeksema et al. 1995). Further, young children of depressed mothers are at risk for insecure attachment with the mother (Cichetti et al. 1998; Demulder and Radke Yarrow 1991; Murray 1992; Teti et al. 1995; Radke-Yarrow et al. 1985; Lyons-Ruth et al. 1986).

Research on the impact of parental depression on children's long-term cognitive development has produced inconsistent results. However, several studies indicate that parental depression is associated with deficits in language development, problem-solving and attention among 4- and 5-year-old children (Hay and Kumar 1995; Sharp et al. 1995; Cox et al. 1987; Coghill et al. 1986; Murray 1988) even after controlling for vulnerability factors such as perinatal complications and social variables (Hay and Kumar 1995; Sharp et al. 1995).

The adverse impact of parental depression on children appears to be mediated by negative behaviors that depressed parents frequently direct toward their children. A recent study found that parental depressive symptoms are powerful predictors of negative parental behaviors (e.g. yelling, spanking) and of a reduced frequency of positive behaviors (e.g. playing, reading, hugging) even after controlling for socioeconomic status and pre-birth stressful events (Lyons-Ruth et al., in press). Other studies have also found that depressed mothers tend to be less responsive to their children, show less affection and involvement than non-depressed mothers (Gordon et al. 1989; Field 1990; Tronick 1989; Cox 1987; Beck 1995; Orvashel et al. 1980), give more negative descriptions of their children in infancy and at 2 and 4 years (Zajicek et al. 1979; Gross et al. 1994), and are more likely to mistreat their children (Bishop and Leadbeater 1999).

Certain variables influence the impact of parental mental illness on children. In general, the younger the child's age at the onset of the parent's mental illness, the greater the risk that the child will experience depression or anxiety disorders later in life (Beardslee 1998). Also, children are at

greater risk for poor mental health outcomes if their parents experience a chronic, unremitting illness or frequent relapses.

The potential negative impact of parental depression on children, combined with the high prevalence of depression among parents, indicates that large numbers of children are at risk if steps are not taken to identify and treat parental depression. A recent study of over 2000 parents found rates of depression of 19% among mothers and 12% among fathers (Lyons-Ruth et al., in press). Rates of depression among fathers became equal to those of mothers when the child care responsibilities fell primarily on the father, suggesting that the burden of child care accounts in large part for the risk of depression. Underscoring this point was the finding that the presence of two or more children at home significantly increases the risk of parental depression. Additional risk factors included ethnicity, with black and Hispanic mothers experiencing the greatest rates of depression (29% and 22%, respectively). Limited financial resources and lack of education beyond high school also added to the risk of depression.

Environmental risk factors, including lack of social supports, stressful life events, parental unemployment, homelessness and marital discord occur more frequently among mentally ill individuals, including parents, than normal controls (Rutter and Quinton 1984; Silverman 1989) and significantly elevate the risk that children will experience psychiatric difficulties (Rutter and Quinton 1984). Persistent marital discord and exposure to hostile behavior within the family especially increase the risk of psychiatric disorders in children (Rutter and Quinton 1984). Also, children may inherit genetic predispositions to mental illness that exacerbate their vulnerability to a parent's mental instability.

Postpartum depression

Postpartum depression, or depression following childbirth, is estimated to occur in approximately 12% of new mothers (O'Hara et al. 1996; Watson et al. 1984; Cooper et al. 1988), with rates doubling for low-income mothers (Hobfoll et al. 1995), particularly if they are adolescents (Panzarine et al. 1995; Leadbeater and Bishop 1994; O'Hara et al. 1995; Koniak-Griffin et al. 1996; Barnet et al. 1996). Despite the high prevalence of postpartum depression, it is a widely under recognized condition (Beck 1995; Barnett et al. 1993) and may be mistaken for postpartum blues, a milder condition that frequently occurs in the first few days following delivery. The lack of recognition of postpartum depression results not only in under treatment of the mothers but has an additional impact on their children. Early interventions are important, as the degree of risk to children appears related to the duration of the mother's depression (Teti et al. 1995; Field et al. 1996; Campbell et al. 1997). Early treatment of maternal depression can significantly reduce adverse consequences to the infant related to that depression, including behavioral problems and patterns of insecure attachment (Cooper and Murray 1997). Infants whose mothers remained depressed over the entire six months following delivery are more likely to score below-average on developmental measures and have lower weight percentiles and higher rates of behavioral problems as preschoolers; in contrast, infants whose mothers' depression has lifted by the sixth postpartum month show normal development by 1 year of age (Field

Although postpartum depression can be quickly diagnosed and effectively treated, perinatal clinics rarely provide screening, treatment or referrals.

et al. 1996). While postpartum depression appears to have an impact on children's outcomes, factors in the infant, such as fussiness or irritability, can exert a negative influence on maternal mood, producing bidirectional influences (Murray and Cooper 1997, p.127). However, maternal factors appear to be of primary significance in the occurrence of infant behavioral disturbance (Murray and Cooper 1997, p.127).

Early treatment of postpartum depression can significantly reduce adverse consequences to the infant's social and behavioral development.

Obstetric clinics rarely assess, much less treat, maternal depression. This situation is especially unfortunate as postpartum depression can be quickly diagnosed and effectively treated. For example, the Edinburgh Postnatal Depression Scale (EPDS)(Cox et al. 1987) is a well-validated instrument that has been successfully used as a screening tool for new mothers in a variety of communities (Reighard and Evans 1995; Thompson et al. 1998; Wickberg et al. 1996; Jadresic et al. 1995; Murray and Carothers 1990; Cox et al. 1993, 1996). A brief self-rated instrument, the EPDS can be completed in less than five minutes and scored immediately (Reighard and Evans 1995), and its return rate of over 97% indicates a high degree of acceptability among postpartum women (Murray and Carothers 1990). It can be administered at prenatal appointments and at birth hospitals and postnatal checks. Another brief, self-rated scale is the Center for Epidemiologic Studies, Depression Scale (CES-D) (Radloff 1977). The CES-D is a 20-item scale that has been validated in English and Spanish and is useful for men and women. Either the EPDS or the CES-D can be administered at new mothers' six-week postnatal check-ups, and women with elevated scores on these scales can be referred for evaluation and treatment. With remission rates reported at over 90% (Stowe 1997), postpartum depression is a highly treatable condition.

A recent study reported that postpartum depression, as measured with the Edinburgh Postnatal Depression Scale, is a powerful predictor of child abuse potential (Cadzow et al. 1999). The use of the EPDS therefore provides not only a method to screen for maternal depression but also identifies families at risk for child maltreatment.

Severe parental mental illness

Severe mental illnesses, such as schizophrenia and bipolar disorder, can impair parents' abilities to identify their children's nonverbal cues and to assist children in regulating their anger and mood swings (Miller 1997; Riordan et al. 1999; Zahn-Waxler, Cummings, et al. 1984; Zahn-Waxler, McKnew et al. 1984). While schizophrenia and bipolar disorder may predispose parents to be less attentive and engaged with their children, these two illnesses do not appear to increase the risk of child abuse (Chaffin et al. 1996; Dinwiddie et al. 1993).

Children of severely mentally ill parents experience more difficulty with social interactions and have been found to share less and display more hostility and impulsiveness at age two (Zahn-Waxler, Cummings, et al. 1984; Zahn-Waxler, McKnew et al. 1984). In addition to the illnesses, the medications used to treat severe mental illness may impair parenting. For example, antipsychotic medications can blunt an individual's spontaneity and facial expressiveness (Nicholson 1994).

Sedating medications given at bedtime may render a new mother unable to respond readily to her baby's cries.

Assessment of parenting capacity in parents with severe mental illness

Mental health providers do not routinely address the parenting status of mentally ill individuals, who are typically viewed as patients rather than family members or parents (Nicholson 1994). In a national survey of state mental health policies and services relevant to pregnant and parenting women, only 16 states indicated that adult patients receiving mental health services were routinely asked about whether they had young children, and only two states, Nebraska and South Dakota, assessed parenting skills (Nicholson 1994).

California's mental health system should do more to enhance parenting skills and support the needs of parents with mental illness.

There is a need to expand the capacity of the mental health system to support parents with mental illness. Services tailored to the special needs of mentally ill families will promote the well-being of both the parents and the children. Further, they will reduce family disruptions resulting from foster care placements when mentally ill adults are unable to function adequately as parents. Even simple and inexpensive interventions, such as improving communication between the departments of mental health, child protective services, child and family services, and general medical services, are likely to have a positive impact in improving families' health and functioning.

The parenting domains listed in Appendix A should be explored in the evaluation of a mentally ill individual's parenting capacity (adapted from Gopfert, Webster, Pollard and Nelki 1996).

Family planning among severely mentally ill individuals

In a study of family planning needs of severely mentally ill women, one-third of women who did not want to become pregnant reported recent unprotected intercourse (Coverdale and Aruffo 1989).

Lack of education about adequate contraception significantly contributes to unplanned pregnancies among severely mentally ill women (Coverdale and Aruffo 1989; Rudolph et al. 1990). Unfortunately, psychiatric patients do not routinely receive education about contraception or family planning issues in mental health facilities. In a survey of patients treated in outpatient mental health clinics, only 10% reported that contraception and family planning issues had been discussed with them (Coverdale and Aruffo 1992). In addition to the lack of knowledge about methods of contraception, multiple other factors contribute to high rates of unprotected intercourse among mentally ill individuals. These include the poor judgment that accompanies many mental illnesses, particularly if they are inadequately treated, and the lack of financial means to pay for contraception.

These issues have become especially relevant now that newer antipsychotic agents (e.g. olanzapine, clozapine) are increasingly used for chronically mentally ill patients. In contrast to the antipsychotic medications that were widely used over the past forty years, most of the newer medications do not

alter levels of reproductive hormones. The reproductive side effects of older antipsychotic agents produced significant health problems, so most clinicians endeavor to switch women to the newer agents. A potential consequence of the medication change is that more women will regain their ability to conceive. This possibility makes it important that contraceptive counseling be provided for mentally ill women who do not wish to become pregnant. Access to affordable means of contraception should also be provided.

Regardless of the methods of contraception that a patient chooses, the use of condoms should be encouraged, as they reduce the risk of HIV transmission. This is especially important for psychiatric patients, who are at increased risk for AIDS compared to nonpsychiatric populations (Aruffo et al. 1990). A study examining knowledge of AIDS found that psychiatric patients showed little understanding of risks of HIV transmission (Aruffo et al. 1990). Methods for reducing HIV risks are particularly urgent for pregnant women because of the risk of transmission to the fetus.

Impact on children of exposure to psychiatric medications during pregnancy or nursing

Several medications used to treat mood disorders and other psychiatric conditions are linked with risk of malformations in children exposed to them during pregnancy. For women on psychiatric medications, it is important that clinicians regularly inquire about the possibility that they may be pregnant, so that fetal exposure to psychiatric medications can be avoided or minimized. Nursing women who begin trials of antidepressant medication often wean their infants because of concern about exposing them to the medication. Recent research has identified several antidepressants that can be safely used by nursing women (Nulman et al. 1996; Taddio 1996; Stowe et al. 1996; Wisner et al. 1998; Yoshida et al. 1998; Hendrick et al. in press). Several studies have evaluated serum concentrations of antidepressant medications in breast-feeding infants (e.g. for sertraline, paroxetine, fluvoxamine) and found them to be undetectable or at very low levels (Stowe et al. 1999, 1996; Hendrick et al. in press). With the exception of doxepin and fluoxetine, no adverse clinical sequelae have occurred in any infant who is breast-fed by a mother on an antidepressant. Health care providers who work with new mothers should be educated about the safe use of antidepressants during nursing, so that they in turn can make recommendations to the nursing women that will not necessarily entail discontinuation of nursing.

Custody issues among severely mentally ill parents

Children of women with severe mental illness frequently enter the foster care system or, less typically, are given up for adoption (Miller and Finnerty 1996). In a study of children born to 80 severely mentally ill women (mostly with schizophrenia), fewer than half were being raised by their mothers (Coverdale and Aruffo 1989). Another survey, of pregnant female inpatients with severe mental illness, found that almost half had previously lost custody of children (Miller 1990). A review of medical records of 23 chronically mentally ill women who had one or more children found that only two were living with their children (Rudolph et al. 1990). This review also noted that custody decisions were typically made with little communication between the mother's treatment team and child protective services.

A key question is whether children of chronically mentally ill women are better off remaining with their mothers or being separated. While more research is needed in this area, the best outcomes appear to be for children who remain with mentally ill parents whose parenting is adequate, even if not optimal (Miller 1997).

III. Evaluation of Existing Systems and Programs

Identification of gaps and redundancies in the system

The public system of mental health care broadened the population of people served when the management of Medi-Cal shifted from the state to counties. The County of Los Angeles Department of Mental Health facilities offer an array of services that are no longer limited to those with serious and persistent mental illness. Services include evaluation and treatment, rehabilitation services, medication management, crisis intervention, assistance obtaining housing and entitlements, inpatient treatment, as well as other case management services on an ability-to-pay-basis. Most clients do not pay anything for services or medications. People in need of services can phone for an assessment appointment (usually a wait of two weeks) or in an emergency walk in to be seen on the same day (usually a several-hour wait). Most facilities are open only during daytime hours. Mental health crises that occur after hours or on weekends are managed by a central phone triage system that can dispatch mental health providers in an emergency. In addition to the county mental health system, mental health services are provided through private primary care providers and mental health clinicians, private psychiatric hospitals and clinics, general hospitals, state hospitals and VA medical centers.

For individuals needing mental health services, a significant obstacle is the stigma attached to attending a mental health facility. Parents of young children may worry that they will be deemed unfit as caregivers if they are perceived as "mental patients."

Mental health screening and referrals

At present, most agencies and providers that see pregnant women and parents of young children do not routinely screen for depression or other mental health problems. One exception is the screening of alcohol and substance abuse, which is widely done, frequently with the use of standardized questionnaires. If a pregnant woman or parent expresses symptoms of depression or other mental health problem, she may be referred for evaluation. Agency staff and providers, however, are frequently unaware of mental health resources for low-income parents, and therefore may provide inappropriate or inadequate referrals. Medical clinics, departments of public social services and children's services do not reliably provide brochures or other informational literature describing common mental disorders and treatment resources.

If a psychiatrist is available, a consultation may be obtained. Women with limited resources may not be able to afford a mental health consultation. Alternatively, an appointment is made for the mother at an outpatient mental health clinic or with a private clinician.

Children of mentally ill parents rarely receive mental health screening despite being at elevated risk for mental health problems.

Coordination of services

There is little communication between county departments of adult mental health, children's mental helth, departments of child and family services, or departments of health services. For example, the Department of Children and Family Services may do an evaluation without ever communicating with the mental health clinicians who have been treating the parent(s).

There is a need for more coordination between adult mental health services, children's mental health services, general medical services and other programs serving parents and children.

Services for children and their families are usually administered separately from those offered for adults with very little cross-over in terms of knowledge about the other programs' services or referrals between programs.

Communication between mental health facilities and other facilities that provide services to a client cannot occur without that client's signed consent for the release of information about his/her care. This requirement can present a huge obstacle to effective collaboration and coordination of services.

In California's mental health system, parenting skills among mentally ill patients are seldom evaluated, nor are services to improve parenting skills readily available.

Parenting skills training for severely mentally ill parents

Parenting skills among mentally ill patients are seldom evaluated, nor are services to improve parenting skills readily available.

The public system incurs significant costs from foster care placements due to parental mental illness, including the costs of litigation resulting when the state moves to terminate parental rights (Blanch and Nicholson 1994). Policies that enhance parenting capacities and improve support systems for parents will promote family unity and reduce such placements and their associated costs.

Innovative approaches

Several creative approaches have emerged across the U.S. that address the needs of mentally ill parents and their young children. We will review two such innovative programs: a county initiative (Los Angeles County's Mental Health Service Delivery Model for Families) and a private/public partnership (The University of Illinois at Chicago's Women's Program).

Los Angeles County's Mental Health Service Delivery Model for Families

The Mental Health Service Delivery Model for Families is an initiative working within CalWORKs (California Work Opportunity and Responsibility to Kids) in Los Angeles County. Many CalWORKs parents suffer from mental health problems such as depression, anxiety, post traumatic stress disorder and substance use disorders. These individuals may also face significant parenting demands if their children have health or mental health disorders or function poorly at school or in the community.

Recognizing that people on welfare are more likely to successfully transition to work if they experience emotional well-being and family stability, the program has made their mental health and parenting needs a priority.

The components of the program include:

- Active outreach to parents and children, including home visits when necessary to engage and support families.
- Formal linkages and close collaboration with multiple agencies, including the Department of Public Social Services, Department of Children and Family Services, Probation Department, domestic violence agencies, vocational assessment and training resources, schools and child care facilities and substance abuse treatment agencies.
- Family- and child-friendly clinics that help children and parents of diverse cultures feel welcomed and comfortable.
- Case management to support the family in obtaining services and resources and in overcoming obstacles to care.
- Service plans that are developed in collaboration with families and are tailored to each family's specific needs and strengths.
- Family therapy to address family concerns and problems.
- Group treatment, including parent support groups, training in parenting skills, and anger management groups.
- Crisis intervention to support families during times of crisis.
- Medication support, e.g., with antidepressants, anxiolytics and other medications.
- Training of mental health providers so that they are able to work effectively with families. The specific skills needed by mental health professionals working in the CalWORKs program include: expertise in working with victims of domestic violence; in diagnosing mental disorders such as post traumatic stress disorder, mood and anxiety disorders, and chemical dependency; in conducting therapy with families; in interviewing and screening children for mental health problems.

The University of Illinois at Chicago's Women's Program

The University of Illinois at Chicago's Women's Program was founded in 1988 to address the needs of parents with mental illness. The program offers multiple services, including the following:

- Parents' Clinic. The program's Parents' Clinic provides parenting coaching and support in addition to psychiatric evaluations and treatment. This services include psychometric measurements related to parenting, home evaluations, and a therapeutic nursery that provides one-on-one parenting training. Also, clinic staff videotape parent-child interactions to review and discuss with parents. A child development specialist and an early childhood educator assess children's developmental outcomes. The start-up costs of the Parents' Clinic were funded by a grant from a private foundation. Funding from the Cook County Department of Children and Family Services has allowed the Clinic to remain in operation.

- Parenting Assessment Team. Another service is the Parenting Assessment Team, which performs forensic evaluations of parents who are at risk of losing custody of their child(ren). Detailed multi-disciplinary custody evaluations are conducted in association with the Cook County Department of Children and Family Services. This team is funded by the Cook County Department of Children and Family Services.

- Inpatient Unit. The program runs a six-bed inpatient unit for severely mentally ill women, in which pregnant inpatients receive prenatal and obstetric care. A nursery close to the psychiatric facility allows for frequent visits between the mother and her newborn. An outpatient clinic offers individual and group psychotherapy, medication management, and family planning services for mentally ill women.

- Outpatient Women's Clinic. An outpatient mental health clinic specializes in the treatment of female-specific conditions, such as the use of psychiatric medications in pregnant and nursing women. This staff at this clinic also provides consultation/liaison services to patients treated through the University of Chicago's ob/gyn services.

- Training. The program additionally trains family court judges and lawyers, staff from the Department of Children and Family Services, pediatricians and family practitioners on the impact of parental mental health on children and on screening techniques to assess parental and child mental health.

While these two programs (CalWORKs and the University of Illinois at Chicago's Women's Program) are examples of innovative approaches to address the mental health needs of parents of young children, formal evaluations of these programs' outcomes have not been undertaken to date.

IV. Integrating and Coordinating Programs and Funding

Sources of funding that are routinely being used

Funding for mental health services in California is provided through a range of public and private sources. For individuals with employer-based health insurance, some resources are available through behavioral health plans associated with general insurance programs.

However, notwithstanding efforts to equalize the treatment of mental and physical illnesses (parity), access to behavioral health services is often severely limited for those with employer-based insurance, and rehabilitative services, including case management, ongoing group support, peer support, and linkages to social services, are rarely available. For parents and others with more severe mental illnesses, regular employment may be difficult to maintain, so other mechanisms must be found to meet their mental health needs. A range of programs offered directly through the Department of Mental Health, or coordinated with Department of Mental Health programs, are available. Efforts to coordinate these programs are already under way, as described further below. While the focus here is on programs administered through, or in coordination with, the Department of Mental Health, other programs will also need to be considered as counties seek to provide care for parents that meets both their needs and the needs of their children.

The Department of Mental Health Budget

The California Department of Mental Health (DMH) provides services through counties. The 1999-2000 Department of Mental Health budget allocated $1.5 billion, representing a 5.1% increase over the previous year.

Subsets of the Community Mental Health portion of the DMH budget that are funded from the $1 billion in local assistance money include:

- Children's System of Care. Approximately $26 million has been allocated for treatment of severely emotionally disturbed children. Currently, 41 counties are funded with a mandate to coordinate a response between Mental Health Social Services, Juvenile Justice and Education agencies.

- Early Mental Health Initiative (EMHI). $15 million from Proposition 98 has been allocated to provide first-time and continuing grants to schools seeking to implement early mental health intervention and prevention services to children 5 to 8 with mild to moderate adjustment problems.

- Local Incentive Grants. The DMH has been budgeted with $10 million in "one-time only funds" for local incentive and expansion grants for counties seeking to integrate services for severely mentally ill adults.

- Brain-Damaged Adult Program/Caregiver Resource Centers (CRC). $9.2 million has been allocated for assessment, planning, respite care, counseling, referral, training, and legal and financial consultation to support a caregiver's efforts to maintain a brain-damaged individual at home as long as possible.

- Supportive Housing. The DMH has allocated $3 million from various sources to provide permanent independent housing for people who are homeless or at a risk of homelessness, including those whose needs involve mental illness.

The Medi-Cal Specialty Mental Health Managed Care Program
This program provides "specialty" mental health services to Medi-Cal beneficiaries, by means of mental health plans which are operated by county mental health departments in 57 of the 58 counties. It has a budget of $169 million, which is matched by federal dollars.

Early Prevention, Screening, Diagnosis and Treatment (EPSDT)
EPSDT follows a federal requirement that all Medicaid beneficiaries ages 0-21 years are entitled to early and periodic screening, diagnosis and treatment for any condition that can be corrected or ameliorated by treatment. When that condition is a mental health disorder or condition, the child receives EPSDT through the county Mental Health Plan. Approximately $200 million has been allocated for this program. Therapeutic Behavioral Services (TBS) is a program that developed under EPSDT and supports extended contact with a child by an experienced service worker when the child or youth is experiencing an imminent life crisis or transitioning to a residential placement or other situation. An additional $1 million of funds supports this program.

Department of Rehabilitation
In the 1999-2000 budget for the Department of Rehabilitation, $416 million is allocated for a wide variety of programs, including Vocational Rehabilitation Services Program (assists individuals in securing, retaining, regaining employment), the Americans with Disabilities Act Implementation Unit (assists state officials in implementing the ADA), Habilitation Services Program (provides funds for community rehabilitation programs oriented toward increasing clients vocational functioning), Work Activity Services (provides paid work/training to reach vocational objectives of clients), Supported Employment (assists clients to maintain competitive employment) and Independent Living Services (associated with the Department of Rehabilitation's programs to assist clients to maintain independent living) and other programs.

CalWORKs
Approximately $50 million in mental health treatment and $55 million in substance abuse treatment funds are made available annually to local Departments of Social Services to be used to fund services by the local mental health and substance abuse departments to serve CalWORKs recipients who need treatment in order to get and maintain employment.

New approaches to mental health systems

In recent years, adult mental health services have been moving toward new models which have developed from novel approaches to children's mental health services in California and throughout the U.S. One such model is the Adult Systems of Care (ASOC), which involves the use of a personal service plan for each client, and a collaborative arrangement that leverages or purchases services to meet a members' needs, including housing, supported and competitive employment, socialization, education, rehabilitation, legal assistance, money management, mental health treatment, and physical health and dental care, counseling and respite care. This model includes strong consumer involvement, both in the design of the program and the determination of each individual treatment plan. Funding is typically through a case rate or a capitation. Programs utilize performance outcomes to gauge success. The ASOC model has been developed for adults of reproductive age but has been

funded for only four areas of the state (Ventura, Los Angeles, Stanislaus and Sacramento) and so is not comprehensive. In addition, the ASOC model does not include routine, tested methods for linking services to the treatment needs of children, even though the personal service plan for each client should include parental needs.

V. Recommendations

- **Identify/Screen parents for mental illness**

Multiple public agencies and providers have routine contact with women and men who are depressed or have mental health problems while parenting young children. These include family planning centers, obstetricians and gynecologists, birth hospitals, WIC programs, pediatric offices, Head Start, and child care centers. At a minimum, these public agencies and providers could provide handouts (in multiple translations) that describe symptoms of common mental disorders and list appropriate community resources for evaluation and treatment. Additionally, parents attending these sites could be screened for depression and other mental health issues. For pregnant women and new mothers, a quick screening can be obtained with the Edinburgh Postnatal Depression Scale or the CES-D, two scales mentioned earlier in this chapter.

- **Facilitate access to care**

Mental health services could be provided at or near sites that parents frequently attend, e.g., WIC centers, child care centers and schools. This strategy would greatly facilitate access to mental health care and would also help reduce the stigma that some individuals associate with mental health facilities.

Public agencies and providers can be provided with lists of local referral agencies and their telephone numbers so that parents can be easily referred for further evaluation.

Mental health screening and treatment services should be provided at or near sites that parents frequently attend.

Services should be offered in nontraditional settings (e.g., schools, churches), or at nontraditional hours, if such approaches will facilitate parents' attendance. Transportation can be provided to mentally ill parents to attend parenting classes and other rehabilitative activities. Couples counseling should be offered to mentally ill parents experiencing marital discord.

- **Provide training to non-mental health providers who have contact with parents**

Child care service staff, preschool teachers, WIC providers, primary care providers, obstetricians/gynecologists, judges and Department of Children and Family Services (DCFS) staff should be educated about typical symptoms of depression and other mental illnesses so that parents and parents-to-be needing mental health services will receive appropriate referrals. These providers can also be trained about how parental mental illness affects children. In particular, it is important

that the training address commonly held stereotypes about the impact of parental mental illness, e.g., that psychiatric disorders prevent individuals from being adequate parents.

➢ **Provide training to mental health providers**

Mental health clinicians should be trained to understand the impact of mental illness on parenting skills and family stability, and to ensure that parenting needs are addressed in clinical planning. Mental health clinicians treating women of reproductive age with psychiatric medications can be trained in methods in the early identification of pregnancy (e.g., asking about the date of the last menstrual period, obtaining beta-HCG) to avoid or minimize fetal exposure to medication.

Mental health clinicians treating sexually active men and women can be trained about methods of contraception so that they can provide informed counseling to their patients.

Mental health clinicians can be educated about child protective services' laws and permanency planning issues so that they can better understand patients' experiences with DCFS and communicate more effectively with staff from child protective services.

➢ **Coordinate systems/programs**

One priority is greater coordination between adult and children's mental health services and other services. To facilitate this coordination, record-keeping requirements and forms can be made uniform across agencies. Clients served by more than one agency (e.g., adult mental health programs, children's mental health programs, social service programs) can receive a single case manager to coordinate all services, rather than a case manager at each agency. Further, any service offered by either program could be offered at either site, allowing clients to choose the site at which to receive services. Some clients may prefer to attend a mental health clinic for all their needs (including parent training, welfare needs), while others may feel more comfortable receiving help (including psychiatric services) at the local social services program or health care facility.

One priority for Proposition 10 commissions should be to increase coordination between adult and children's mental health services and other services.

Any site can be a point of entry into other service. For example, when adults or children enter the health care system through general medical or pediatric services, these could facilitate links with adult and children's mental health services and social services.

➢ **Increase collaboration among agencies serving severely mentally ill**

Collaboration between multiple agencies, including DMH, the Department of Public Social Services (DPSS), DCFS, probation departments, schools, child care facilities, domestic violence agencies, substance use treatment programs, and vocational rehabilitation programs, is essential for diverse needs of families to be effectively addressed. Staff from child protective services should involve the parents't reating clinicians when making custody decisions. These clinicians (psychiatrists, social

workers, etc.) are sources of essential information: the specific symptoms of the parent's mental illness, the parent's compliance with treatment, his/her insight into their illness, his/her prognosis, and other clinical issues that are highly relevant to parenting. Clinicians can also be of great assistance in reducing stigma and stereotypes about parenting among mentally ill individuals.

A significant obstacle that providers face in trying to communicate with one another about an individual client is the need for the client's signed consent to have information released about him/her. Decisions that significantly affect the life of a child (such as removal of the child from parental custody) should be made only once providers responsible for the care of both the parent and the child have exchanged information. To facilitate such communication, providers should encourage all clients to sign confidentiality waivers, helping them understand that the purpose of interagency communication is to promote family functioning, well-being, and unification.

➢ **Intervene with children of mentally ill parents**

Mental health providers who work with parents should receive training in the assessment of parenting skills and in screening children for indicators of mental health problems.

Intake evaluations of adults with mental illness should routinely assess parenting status. If the patient's illness is severe or prolonged and the patient is parenting a young child, mental health professionals should recommend that the children undergo mental health screening.

For many children, a parent's mental illness produces marked confusion, shame and guilt. These children should be provided with opportunities to express their feelings with mental health professionals and to get their questions answered about their parent's illness.

➢ **Optimize parenting abilities among severely mentally ill individuals**

Parenting assessments and education should routinely be offered to mentally ill parents.

Parental status should be added to DMH uniform patient intake forms to prompt clinicians to explore this issue.

Parental status should routinely be addressed among individuals receiving mental health services. Parenting evaluation and education should be easily available to any mentally ill individual who is a parent.

Permanent or temporary housing, with various levels of supervision, should be developed to meet the diverse needs of mentally ill parents and their children.

➢ **Provide family planning for severely mentally ill adults**

Contraceptive counseling can be offered at mental health clinics. These clinics are frequently the only health care facility that mentally ill individuals attend on a regular basis. If they do not receive access to contraception at the mental health facility, they

may not receive it all. Contraceptive methods that should be made available include condoms, as they provide for both contraception and protection against STDs and HIV transmission.

Adults who receive services in mental health facilities should be asked about their plans for future pregnancies. Strategies for contraception should be reviewed for men and women not wishing to conceive.

Intake forms of adult clients should include items about current methods of contraception, to routinely prompt these questions.

- **Bolster community support**

Peer educators can be trained to deliver direct, in-person family planning and counseling, as in Maine, where ongoing TANF recipients work as peer counselors to new TANF recipients.

- **Hold public hearings**

New York created a task force in 1992 to examine the prevalence of parenthood among mentally ill individuals, identify ways for the child welfare system to work effectively with mentally ill parents and their children, and identify strategies to reduce family disruption and foster care placements due to parental mental illness. The task force consisted of clients and professionals from New York's Departments of Mental Health and of Social Services and held public hearings (Blanch and Nicholson 1994). Similar hearings could be held in California to provide a forum for people who suffer from mental illness or who deliver services to mentally ill individuals to help identify the unmet needs of mentally ill parents.

VI. Appendix A: Parenting Domains to be Explored in Parents with Mental Illness

Focus on parenting:

- Capacity to attend to child's physical, intellectual, social and emotional needs
- Capacity to provide a stable and nurturing environment
- Age-appropriate understanding and expectations of child
- Capacity to initiate or follow and enjoy child-centered activity
- No evidence of physical or sexual abuse

Focus on mentally ill parent:

- Level of disturbance, instability and violent tendencies (impulse control)
- Behavior and psychiatric symptoms directly affecting parenting capacity and ability, including alcohol and drug addiction
- Sense of responsibility for self, child and family
- Capacity to acknowledge any risk to child
- Level of paranoia
- Capacity to form trusting relationships
- Use of help/clinical interventions

Focus on other parent, if relevant:

- Attitude toward partner's illness
- Relationship to child
- Commitment to maintaining the family
- Capacity to intervene on child's behalf if and when necessary

Focus on the marriage/partnership if relevant:

- Style and intensity of marital conflict
- Ability to communicate
- History of domestic violence

Focus on the child:

- Developmental progress
- Child's attachment status
- Capacity for self-protection
- Unusual behaviors or characteristics
- Relationships outside nuclear family

Focus on context:

- Financial/housing status
- Environmental stress
- Quality of non-family network
- Quality of home environment (ideally assessed through home visit)

VII. Appendix B: Resources

Useful web sites

1. Clearinghouse on Elementary and Early Childhood Education: www.ericeece.org
2. Boston Institute for the Development of Infants and Parents: www.medicalboston.com/bidip
3. Zero to Three – National Center for Infants, Toddlers and Families: www.zerotothree.org
4. Positive Parenting: www.positiveparenting.com
5. PACER Center (nonprofit organization that serves families of children with physical, mental or learning disabilities): www.pacer.org
6. Department of Mental Health, State of California: www.dmh.ca.gov
7. California Council of Community Mental Health Agencies: www.cccmha.org
8. California Network of Mental Health Clients: www.cnmhc.org
9. People Who Information Center: www.peoplewho.net
10. Mary Ellen Copeland, MS, MAS – Self-Help Strategies for Dealing with Depression, Manic Depression and other Psychiatric Disorders: www.mentalhealthrecovery.com
11. Monterey Mental Health Network: www.mentalnet.com
12. National Alliance for Mentally Ill: www.nami.org
13. Mental HealthNet: www.cmhc.com
14. National Institute of Mental Health: www.nimh.nih.gov
15. Internet Mental Health: www.mentalhealth.com
16. Center for Mental Health Services (CMHS): www.samhsa.gov/cmhs/cmhs.htm

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